STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105234	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation and Healthcare Center of Tampa	4411 N Habana Ave Tampa, FL 33614

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14161 50732 Based on record reviews and interviews, the facility failed to prevent falls/accidents resulting in an injury to one resident (#1) out of three residents sampled for falls. Resident #1 sustained a scalp hematoma and clavicle fracture with a transfer to a higher level of care. Findings included: Review of the Admission Record showed Resident #1 was originally admitted to the facility in 2017 and discharged to a local hospital on 07/16/2024. The Admission Record showed diagnoses to include: other sequelae following unspecified cerebrovascular disease, muscle wasting and atrophy, dementia, weakness, lack of coordination, and need for assistance with personal care. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 3 showing severe cognitive impairment. The resident had no mood or behaviors identified, and no falls since the prior MDS assessment dated [DATE]. The resident required substantial/maximal assistance with rolling left and right, was always incontinent of bowel and bladder, and was dependent on a helper to perform all effort for toileting hygiene. A review of the comprehensive Care Plan initiated on 4/11/2018 with a goal revision date of 4/17/2024 showed: -Focus: The resident has impaired thought processes r/t Dementia. Interventions included: Explain care before providing it. Face the resident when speaking and make eye contact if possible. Provide orientation and validation. -Focus: The resident has an Activity of Daily Living (ADL) Self Care Performance Deficit as evidenced by: Cannot complete ADL tasks independently and safely, requires individualized interventions to maintain because of weakness, fatigue, impaired cognition, and fear of falling. -Interventions included: Bed Mobility: Assist of 2 to turn and/or reposition. TRANSFER: Total Mechanical Lift to chair of 2 assist. PERSONAL HYGIENE: Assist of 1. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Focus: Fall-The resident is at risk for falls or fall related injury because of cognitive and sensory factors: dementia, poor safety awareness, fearfulness, and medication side effects. -Interventions included: Provide environmental adaptations: low bed. A review of the Certified Nursing Assistant (CNA) Patient Care Kardex dated 07/27/2018 for Resident #1 showed: -Transferring: Total Mechanical Lift to chair of 2 assist -Bed Mobility: Assist of 2 to turn and/or reposition -Personal Hygiene: Assist of 1 A review of the Physical Therapist progress and Discharge Summary dated 7/16/2024 revealed Resident #1 did not meet the bed mobility goal to roll from side to side with minimum assist (1-25% assist) with 40% tactile and verbal instruction/cues in order to improve safety and independence with functional bed mobility tasks. The bed mobility status as of 7/16/24 was able to roll from side to side with moderate assist (26-75% assist) with 60% tactile and verbal instruction/cues. There was no documentation in the clinical record to show the resident independently rolled from side to side without staff assistance and no documentation showed the number of staff needed to assist with bed mobility or transfers had decreased from 2. A review of Nursing Notes and Progress notes for Resident #1 showed: -7/16/2024 8:00 pm Progress Note: During resident care the CNA rolled resident onto her side to provide pericare and repositioning. The resident rolled over before the CNA could stop her which resulted in the resident rolling out of the bed. Neuro checks done. within normal limits (WNL). Vital signs stable. Laceration noted to left temple and left forearm. Resident moves all extremities without difficulty. 911 called to transfer to ER for evaluation. A review of the medical transportation (ambulance) Patient Care Report dated 7/16/2024 signed by an Emergency Medical Technician (EMT) showed: -Medical Transportation received call at 7:50 pm on 07/16/2024 and arrived at the facility at 8:02 pm. -Resident #1 complained of head pain secondary to a fall. Resident #1 had rolled off their bed and hit their head on the wooden floor. -The assessment for Resident #1 showed a golf ball size hematoma to the left side of Resident #1's head with some controlled bleeding. The resident also had a skin tear on her left elbow that was already bandaged. A review of the Hospital Discharge Summary for Resident #1 dated 07/19/2024 showed a diagnoses list to include clavicular fracture, fall, ground-level fall, hyperkalemia, hyponatremia, and NSTEMI (non-segment [ST] elevated myocardial infarction) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Shoulder x-ray findings showed an acute, mildly displaced fracture of the left distal clavicle. -Computed Tomography Head (CTH) showed a moderate sized left frontal scalp hematoma. An interview with Staff A, CNA, on 08/19/2024 at 3:00 pm revealed she went to Resident #1's room to provide evening care on 7/16/2024. She saw the resident had a large bowel movement and she rolled the resident on her right side to clean her up. Staff A reported turning her head from the resident to call out for Staff C, CNA, to come into the room to help her clean the resident up. Staff A reported Staff C never came to the room. Staff A said when she turned her head, the resident rolled out of the bed onto the floor. She said she ran out of the room to get the nurse. She stated the resident had never done that with her before. Staff A said she went back into the room and other CNAs came into the room to help. She said they moved the furniture out of the way, and they were debating on whether or not to move the resident back to her bed. She said the nurse told them not to move the resident, so they did not. Staff A said she was sent home and did not return to work until the following Monday (7/22/24). She did not know what happened to the resident after she went to the hospital. The resident was not in the facility when she returned to work. An interview was conducted with Staff B, CNA on 08/19/2024 at 3:30 pm. Staff B said she was outside of Resident #1's room documenting on 7/16/2024 when the incident occurred. She was not taking care of the resident that night, but she said she had taken care of the resident several times before. She said she went to the room after the resident fell out of the bed and saw the resident on the floor with her head next to the cabinet. She asked the resident if she was ok, and the resident said yes. Staff B reported the bed was raised to the height to perform resident care. She said the nurse came in the room to help the resident, and Staff B, CNA left the room to continue documenting. Staff B, CNA said when she has taken care of the resident in the past, she always had another CNA help her if the resident needed to be cleaned up. She said you always need two people when this resident needs care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Nursing Home Administrator (NHA) on 08/19/2024 at 4:00 pm. The Registered Nurse (RN) Risk Manager was in attendance, but did not answer any questions. The NHA said on 7/16/2024 he and the Risk Manager were notified by staff that Resident #1 had a fall during care. He said staff was interviewed immediately after the incident. He said when Staff A went to Resident #1's room to get her settled for bed, Staff A saw the resident had a large bowel movement, and Staff A decided to clean the resident up. The NHA said Staff A raised the bed to the ergonomic height to provide care to the resident. He said at first, Staff A thought she could take care of it herself and rolled the resident on her side and called out for help. Staff A needed more supplies. The NHA said Staff A could not remember if she turned her head from the resident or not when calling for help. He said Staff A was in shock over what happened. He stated the bed was moved out of the room to provide assistance to the resident after the fall. The NHA said the resident was reaching for her snacks on the bedside table and rolled out of the bed. He said the resident was always hungry, and the family brings her snacks. He said by the time Staff A turned around, the resident was on the floor. The NHA said other staff members told him Resident #1 could be quick. He said they called 911, and the resident was sent to the hospital to get checked out. He said they were informed by the hospital the resident's Computed Tomography (CT) scan was negative for a head injury. He said they did a reenactment of the incident with the staff who were involved. Staff A said to the NHA she can take care of the resident by herself when she needs to be changed, but since it was a large bowel movement she called for help. The NHA said that turning this resident on her side would be a one person assist because Staff A was performing hygiene care. The NHA also said since the resident was turned on her side, it could be considered a two person assist stating, It could be considered both ways. The NHA said after completing the investigation it was determined the incident was unsubstantiated for neglect. However, a review of a facility report dated 7/23/24 revealed Abuse, Neglect, Exploitation, and Misappropriation (ANEMI) education was completed for all staff on 7/22/24.